STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155625	B. WIN	G		02/12/	2013
	PROVIDER OR SUPPLIE GROVE VILLAGE SUMMARY S	R STATEMENT OF DEFICIENCIES		1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE ISBURG, IN 47240		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F0000	This visit was State Licensur included the Ir Complaint INO Complaint INO Substantiated deficiencies reare cited at F-Survey dates: and 12, 2013 Facility number Provided number AIM number: Survey team: Sharon Lashe Angel Tomlins Barbara Gray Leslie Parrett Census bed ty SNF/NF: 64 Total: 64 Census payor Medicare: Medicaid: Other:	for a Recertification and re Survey. This visit hyestigation of 0123230. 0123230 Federal/State elated to the allegations 309 and F-425. February 5, 6, 7, 8, 11 er: 000305 ber: 155625 100287200 or RN, TC ton RN RN RN RN RN	F00		The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credibilial allegation and requests a deskreview in lieu of a Post Complis Survey Revisit on or after Man 4, 2013.	t s n of le c aint	DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625			(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 02/12		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	These deficient findings cited in IAC 16.2				CROSS-REFERENCED TO THE APPR	OPRIATE		

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Event ID: XZPZ11

Facility ID: 000305

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155625	A. BUIL			02/12/	2013
			B. WING		DDDEGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
40000					CENTRAL AVE		
ARBUR	GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	483.10(b)(11)					•	
SS=D	NOTIFY OF CHA	NGES					
	(INJURY/DECLIN	NE/ROOM, ETC)					
	A facility must im	mediately inform the					
	· ·	with the resident's					
		known, notify the resident's					
		ive or an interested family					
		ere is an accident involving					
		h results in injury and has					
	•	equiring physician					
		gnificant change in the					
		al, mental, or psychosocial					
	•	erioration in health, mental,					
	threatening condi	tatus in either life					
	•	need to alter treatment					
		a need to discontinue an					
		reatment due to adverse					
	_	r to commence a new form					
	•	a decision to transfer or					
		ident from the facility as					
	specified in §483.						
	.,	(-)					
	The facility must	also promptly notify the					
		nown, the resident's legal					
	representative or	interested family member					
	when there is a c	hange in room or					
	roommate assign	ment as specified in					
		a change in resident rights					
		State law or regulations as					
	specified in parag	graph (b)(1) of this section.					
		record and periodically					
		ss and phone number of					
	_	al representative or					
	interested family		EAT				02/05/2012
		view and record	F01:	5/	What corrective action(s) will	1	03/05/2013
	review, the faci	ility failed to notify the			be accomplished for those		
	physician of a i	resident's significant			residents found to have been	l	
	weight loss for	1 of 26 residents			affected by the deficient		
		nysician notification			practice? Resident #52 no lon	-	
		.,			resides in the facility How other	er	

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Event ID: XZPZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLET	ED
		155625	- 1	LDING		02/12/20	
		100020	B. WIN			02/12/20	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(Resident #52)).			residents having the potenti	al	
					to be affected by the same		
	Finding include	e:			deficient practice will be		
	J				identified and what corrective	/e	
	Review of the	record of Resident #52			action(s) will be taken?All		
					residents have the potential	to	
		9:00 a.m. indicated the			be affected by the alleged		
	_	noses included, but			deficient practice.Licensed		
	were not limite	ed to, congestive heart			nurses were educated on		
	failure (CHF),	anxiety, paraplegia and			notifying a Physician for any resident with a significant wei	aht	
	multiple sclero	sis (MS).			loss, and to implement	gnt	
					interventions to prevent weigh	nt	
	 Pasident #52 v	was admitted to the			loss by the DNS/designee on		
					2/28/2013. All residents were		
		-12 and weighed 126			reviewed for significant weigh		
	·	esident's weight on			loss by the DNS/designee. N		
	8-30-12 was 1	15; this indicated a 8.7			other residents were		
	% weight loss	since admission.			identified.Residents identified	with	
	_	s weight on 8-31-12			a significant weight loss or ga	in	
	was 117.	3			will be reviewed in weekly NA	R	
					meeting to include weight his		
	The Minimer	Data Sat (MDS)			current nutrition regimen, oral		
		Data Set (MDS)			status, observations during		
		r Resident #52, dated			meals, root cause, plan of car	re	
	8-31-12 indica	ted the resident was			updated, and physician and	_	
	not on a physic	cian prescribed weight			responsible party were notifie		
	loss regimen.	-			to be attended by the DM, RD	וו (
					available, DNS, RSM, MDS Coordinator, and/or		
	Interview with	the Director of Nursing			Designees. Non-compliance	with	
		•			these procedures will result in		
		9:25 a.m. indicated the			further education including	.	
		not notified of Resident			disciplinary action.DNS/desig	nee	
	#52's weight lo	OSS.			are responsible to ensure		
					complianceWhat measures v	vill	
	Interview with	the Dietary Manager on			be put into place or what		
		15 a.m. indicated			systemic changes will be ma	ade	
		esponsible to notify the			to ensure that the deficient		
	_	•			practice does not		
		esident #52's significant			recur? Licensed nurses		
	weight loss.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155625	A. BUILDIN	IG	00	02/12/	
		133023	B. WING			02/12/	2013
	PROVIDER OR SUPPLIE GROVE VILLAGE	R	10	021 E (.ddress, city, state, zip code CENTRAL AVE SBURG, IN 47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Administrator a.m., indicated department is identifying the significant unpand meeting wand meeting wand manager. The	responsible for resident with a lanned weight loss/gain vith the Dietary service physician was also lificant or undesirable			were educated on notifying a Physician for any resident with significant weight loss, and to implement interventions to prevent weight loss by the DNS/designee on 2/28/2013. Residents identified with a significant weight loss of gain will be reviewed in weekly NAR meeting to include weight history, current nutrition regime oral status, observations durin meals, root cause, plan of care updated, and physician and responsible party notifed - to lattended by the DM, RD if available, DNS, RSM, MDS Coordinator, and/or Designees. Non-compliance with these procedures will result in further education including disciplinary action. DNS/designare responsible to ensure compliance How the correctivaction(s) will be maintained the ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? The CQI audit tool for reside weights will be utilized weekly 4 weeks and then monthly for months. Findings from the CQI proceing will be reviewed monthly by the Quality Assurance Committee and an action plan will be implemented for threshold belongow.	d r / t en, g e oe with nee o ty ut ent for 6 ess e	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPLETED	
		155625	B. WIN			02/12/	2013
VIII OF P			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	-		1021 E	CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	
		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0250 SS=D	483.15(g)(1) PROVISION OF I SOCIAL SERVIC The facility must p social services to highest practicabl psychosocial well Based on interview, the faci social service a resident's code resident's healt resulting in the being changed Do Not Resusciperson who was resident to make code status, for reviewed who reviewed who reviewed who resident (Resident Finding include Review of the ron 2-11-13 at 1 the resident's divere not limited failure, anemia airway obstruct Resident #90's most current data	attain or maintain the attain or maintain the attain or maintain the aphysical, mental, and abeing of each resident. View and record ality failed to provide assistance with a status when the ath had declined, are sident's code status from a full code to a sitate (DNR) by a as not authorized by the ate the decision of his ar 1 of 1 resident met the criteria for att#90).	F02	PREFIX TAG	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #90 no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have to potential to be affected by the alleged deficient practice Licensed nurses and Social Service Staff were in-serviced on 2/28/13 by the Executive Director and the Director of Nursing Services on code status for residents, what constitues an authorized representative, updating face sheet when status changed and reporting to oncoming shift who status has changed. 100% aud was completed on residents current code status to ensure available to nursing staff by the Executive Director and SSD on 2/26/13. Any resident found to not have a current code	nt the e	O3/05/2013
	away on 1-7-13	ne resident passed 3.			status will immediately be updated by SSD/designee speaking to resident/responsib	le	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	DDIC	00	COMPL	ETED
		155625		LDING		02/12/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹					
ADDOD					CENTRAL AVE		
ARBOR	GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The admission	record, dated 9-16-12			party for information, physiciar		
	for Resident #9	90 indicated he was a			notification, order obtained and		
	full code (Card	iopulmonary			resident face sheet and care p		
	,	[CPR] will done and			updated. Non-compliance wit		
		•			these procedures will result in		
		aving measures			further education including disciplinary action.DNS/design	100	
	needed) and th				and SSD/designee are	i C C	
	•	an emergency contact			responsible to ensure		
	person.				complianceWhat measures w	ill	
					be put into place or what		
	The careplan f	or Resident #90, dated			systemic changes will be ma	de	
	8-8-12 indicate	ed the resident had			to ensure that the deficient		
		staining measures. The			practice does not		
		esident would receive			recur? Licensed nurses and		
	•	mbulance would be			Social Service Staff were		
					in-serviced on 2/28/13 by the		
		erventions were assess			Executive Director and the		
		y condition changes,			Director of Nursing Services o		
	make resident	comfortable and notify			code status for residents, wha constitutes an authorized	[
	family of condi	tion changes.			representative, updating face		
					sheet when status changed ar	nd	
	The careplan f	or Resident #90, dated			reporting to oncoming shift wh		
	•	ed the resident planned			status has changed. 100% aud		
		the community. The			was completed on residents		
	_	esident would be			current code status to ensure		
	discharged to I				available to nursing staff by the		
					Executive Director and SSD of		
		vere explore with the			2/26/13. Any resident found to)	
	resident and fa	•			not have a current code status will immediately be		
		e community, keep			updated by SSD/designee		
	resident and fa	mily apprised of			speaking to resident/responsit	ole	
	progress towar	rd discharge goals and			party for information, physiciar		
		aluation as appropriate.			notification, order obtained and		
					resident face sheet and care p		
	The social sen	vice progress note for			updated. SSD/designee will		
	Resident #90,	. •			ensure appropriate paperwork		
					available to designate resident	Į.	
		esident was able to			specific authorized		
	make his own	daily decisions as he is			representative. ED/designee	WIII	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED
		155625	A. BUI B. WIN			02/12/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		1		
ADDOD					CENTRAL AVE	
ARBUR	GROVE VILLAGE			GREEN	ISBURG, IN 47240	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	able to make h	nis self understood with			review POA paperwork when	
	a clear spoken	voice and understands			there is a change in CPR/DNF	
		sident was at the facility			status to ensure appropriate	
		n stay and plans on			paperwork is consistent with	
		e. The resident was a			current authorized	
	_				representative. Non-complian with these procedures will resi	
	full code status	5.			in further education including	ATC
					disciplinary action.DNS/design	ee
		vice progress note for			and SSD/designee are	
	Resident #90,	dated 11-13-12			responsible to ensure	
	indicated the re	esident was able to			compliance How the correctiv	е
	make his own	daily decisions and			action(s) will be maintained t	o
		understood as well as			ensure the deficient practice	
		ners. The resident was			will not recur, i.e., what quali	ty
					assurance program will be p	ut
		or a short term stay and			into place? The CQI tool for	
	was a full code	e status.			advanced directives will be	
					utilized weekly for 4 weeks an	d
	The social serv	vice progress note for			then monthly for 6	
	Resident #90,	dated 12-31-12			months. Findings from the CO	
	indicated the re	esident was able to			process will be reviewed mont by the Quality Assurance	rily
	make his own	daily decisions. The			Committee and an action plan	will
		n the facility for a long			be implemented for threshold	Will
		•			below 90%.	
	l cilli stay allu	was a full code status.				
	_,					
		vice progress note for				
		dated 1-7-13 indicated				
	the resident's	code status form was				
	signed and dat	ted. The code status				
	_	to the physician for a				
	signature.	, ,				
	Peview of the	"State of Indiana out of				
	hospital Do No					
		d order" indicated				
	Resident #90's	s code status was				
	changed to DN	IR on 1-7-13. The form				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625			(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/12/2013
	PROVIDER OR SUPPLIE GROVE VILLAGE	R	1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE NSBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	had the reside witnessed by I	nt's name on it and was LPN #1.			
		note for Resident #90, at 11:30 p.m. indicated ad expired.			
	Director (S.S.I. a.m. indicated spouse gave to the resident's code to a DNF on 1-7-13, the away. The S.S. spouse made resident after the S.S.D. indicated full code and holicated the resident had whose his health corresident had whose his health composed to indicated she was no legal possible to the extra spouse health care represented the decirindicated the extra spouse health care represented the decirindicated the extra spouse health care represented the second control of the s	the Social Service D.) on 2-11-13 at 10:30 Resident #90's ex the approval to change code status from a full and signed his name same day he passed D. indicated the ex the choice for the his health declined. The ed the resident was a had planned on being thome. The S.S.D. resident's health had d. The S.S.D. indicated documentation that the ranted his ex spouse to hare representative or recy (POA). The S.S.D. did not realize there aperwork appointing to be the resident's resentative or POA to sion. The S.S.D. ex spouse told her that e over the resident's cisions.			

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				ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155625	B. WIN	G		02/12/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREEN	SBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		_PN #1 on 2-11-13 at					
	10:45 a.m. indi						
		ident #90's DNR code					
		and signed it. LPN #1					
		esident's ex spouse					
	was the one wl	•					
		e. LPN #1 indicated					
	•	did not tell the facility					
		sident's health care					
	representative	or POA.					
	The "Advence	A Directives and					
		Directives and					
	Treatment" pro	nts to Refuse Medical					
	•	on 2-12-13 at 11:15					
		"where a resident no					
		acity and someone					
		ct on resident's behalf,					
	_	rify the legal standing					
	,	the representative who					
		n the DNR order."					
	_	te law, authority may					
	be/have been (
	•	in a number of ways:					
		care, guardianship,					
		of Attorney, spouse,					
		nts, adult children and					
	surviving siblin	ys.					
	2 1 24(2)						
	3.1-34(a)						

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Event ID: XZPZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE S	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DING	00	COMPL	ETED
		155625	A. BUII			02/12/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.		l	ADDRESS, CITY, STATE, ZIP CODE		
4 D D O D (CENTRAL AVE		
ARBUR	GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	CARE PLAN	UALIFIED PERSONS/PER					
		vided or arranged by the					
		rovided by qualified					
		dance with each resident's					
	written plan of ca		F03	02	l		02/05/2012
		ervation, interview, and	F02	82	What corrective action(s) will		03/05/2013
		the facility failed to			be accomplished for those residents found to have been		
		nt's Restorative Plan of			affected by the deficient		
		6 residents reviewed			practice? Resident #97 is		
	for care plans.	(Resident #97)			recieving restorative services	oer	
					residents restorative plan of		
	Findings includ	le:			care How other residents		
	J				having the potential to be		
	Resident #97's	record was reviewed			affected by the same deficier	nt	
		41 P.M. Resident #97			practice will be identified and		
	was admitted to				what corrective action(s) will		
		diagnoses included,			be taken?All residents have t		
		•			potential to be affected by the	е	
		nited to, cerebral palsy,			alleged deficient		
	peripheral neur				<pre>practice.Restorative c.n.a.'s w educated on following a reside</pre>		
		nultiple sites, and pain			restorative plan of care and	1115	
	•	luding the forearm,			completing the restorative		
	pelvis, and thig	h. He had one fall.			flowsheet on 3/1/13 by the MD	S	
					Coordinator/designee. All		
	Resident #97's	quarterly MDS			restorative programs were		
	(Minimum Data	a Set) assessment			reviewed with restorative CNA		
	•	indicated he was			to ensure that restorative CNA	i'S	
	,	d understood others.			were educated on current restorative plans by the MDS		
		iew for Mental Status			Coordinator on 3/1/13.The MD)S	
		indicating he was			Coordinator/designee is		
		ct. He required	1		responsible to monitor for		
		·			compliance. Non-compliances		
	•	1 person to transfer.			with these procedures will resu		
		is room. He required			in further staff training includin		
	-	d set up only for toilet			disciplinary action if necessary		
	use. He had n	o functional limitations			What measures will be put in	to	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		155625	B. WIN			02/12/2	013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	8			CENTRAL AVE		
ARBOR (GROVE VILLAGE				ISBURG, IN 47240		
						<u> </u>	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		+	DATE
	_	f motion in his upper or			place or what systemic		
	lower extremiti	es. He utilized a			changes will be made to		
	walker and wh	eelchair.			ensure that the deficient		
					practice does not		
	A PT (Physical	Therapy) Progress			recur? Restorative c.n.a.'s we		
	, ,	Summary for Resident			educated on following a reside	ints	
	_	•			restorative plan of care and completing the restorative		
		/13, for the time period			flowsheet on 3/1/13 by the ME	$_{\rm os}$	
		til 1/21/13, indicated			Coordinator/designee. All new		
	_	"Discharge Plans: to			restorative programs will be		
	stay in facility \	vith restorative			reviewed with the restorative		
	program."				c.n.a.'s by the MDS		
					Coordinator/designee prior to	the	
	An OT (Occur	ational Therapy)			initiation of the program.MDS		
	, ,				Coordinator/Manager on Duty		
	_	Discharge Summary for			conduct rounds Monday throu		
		lated 2/1/13, for the			Saturday to ensure the restora		
	time period of	1/17/13 until 2/1/13,			care plan is followed for reside	ents	
	indicated the fo	ollowing: "Discharge			participating in restorative		
	Plans: RNP" (Restorative Nursing			care.The MDS		
	Program).				Coordinator/designee is responsible to monitor for		
	,				compliance. Non-compliances		
	Δ Restorative I	Flowsheet indicated the			with these procedures will resi	I .	
					in further staff training includin		
		for Resident #97,			disciplinary action if	~	
		4/13: Resident #97			necessary. How the corrective	ve	
) feet, 6 days a week,			action(s) will be maintained t		
	using a rolling	walker with standby			ensure the deficient practice		
	assistance. Th	ne Restorative			will not recur, i.e., what quali	ty	
	Flowsheet indi	cated Resident #97			assurance program will be p	ut	
		d for 15 minutes on			into place? The CQI tool		
		s, 29, 30, and 31, 2013.			for restorative nursing (Fit		
	•				Program) will be utilized week		
		nad participated for 15			for 4 weeks then monthly for 6		
		oruary 1, 4, 5, 6, 7, and			months. Findings from the CC		
	8, 2013.				process will be reviewed by th	I .	
					Quality Assurance Committee		
A Restorative Flowsheet indicated the				monthly and an action plan wi implemented for threshold below			
	following order	for Resident #97,			90%.	U 1	
1		•	1		• •		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/12/2013
	PROVIDER OR SUPPLIEF	3	1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE ISBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE	D BE COMPLETION
	would perform range of motio to his bilateral using 2 pound week. The Reindicated Resid participated for January 25, 28 Resident #97 himutes on Fel 8, 2013. On 2/7/13 at 1 #97 was obserwatching TV. longer in therautilized a walke He indicated hanywhere in the walker, and he walker, and he walker sometime becoming more wheelchair. On 2/7/13 at 1 #97 was obserwheelchair from his bedroom, uhe stated "yeato lunch today." On 2/8/13 at 1 #97 indicated was a motion of the stated "yeato lunch today."	r 15 minutes on 8, 29, 30, and 31, 2013. The principal of			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155625	B. WIN			02/12/	/2013
NAME OF I	PROVIDER OR SUPPLIE	TD.	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIE				CENTRAL AVE		
ARBOR	GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		entrated mainly on his					
		ties. He indicated he					
		ntly in any exercise					
		ne sometimes walked					
		way using his walker by					
		ndicated he did not walk					
	_	er with any of the staff.					
		ne knew he should not					
		wn the hallway using his					
		t staff with him. He					
		lid not do any arm					
	exercises "except getting in and out of						
	bed."						
	0.5 0/0/40 54 4	10:00 A.M. Daataaathaa					
		0:30 A.M., Restorative					
		ited she worked					
	Monday throu	-					
		ide #5 worked Sunday					
	_	day. She indicated					
		was on Restorative					
		e load but she worked					
		#97 when she was off.					
		she made sure he was					
		indicated he also					
	'	arm exercises in his					
	room, includin	g his wrist, and fingers.					
		he did not use any					
	weights when	he performed his arm					
	exercises.						
	0 2/0/40 -1 4	IO.EO A M. Dantamatica					
		0:50 A.M., Restorative					
		bbserved walking with					
		down the hallway from					
		o the dining room. She					
	I was holding o	nto a gait belt around					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	E CONSTRUCTION	r í	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED	
		155625	B. WING			2/2013	
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP C	ODE		
ADDOD (GROVE VILLAGE			E CENTRAL AVE ENSBURG, IN 47240			
				:ENSBURG, IN 47240		_	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE		(X5) COMPLETION	
TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		DATE	
		ne utilized a rolling					
	walker.	io atmizoa a roming					
	On 2/11/13 at	10:16 A.M., Restorative					
	Aide #5 indicat	ed she had been					
	walking Reside	ent #97 in the hallway					
		She indicated she					
	_	t and he utilized a					
		dicated Resident #97					
	•	AROM to his upper					
		emities. She indicated					
		e any weights with him					
	_	cises. She indicated					
		sident's Restorative					
	•	looking at the order on Provider Inc.					
		locumented Resident					
		tion on the Restorative					
	• •	e indicated she did not					
		supposed to use					
	weights "until I						
		owsheet just now." "I					
		I the 2 pound weight on					
	the Restorative	Flowsheet for					
	AROM."						
		10:45 A.M., Resident					
		occasionally staff					
		ne hallway with him					
		his walker but not very					
		supposed to walk by					
	•	to be in therapy and					
	-	th me." He indicated					
		nto his room and had					
	mini exercise n	is arms or legs. "I					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155625	A. BUILDING		00	02/12/		
		103023	B. WING		PRESIDENCE CONTROL CON	02/12/	2015	
NAME OF F	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE			
ARBOR (GROVE VILLAGE				SBURG, IN 47240			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE	COMPLETION	
TAG		by myself if I wanted to,	TAC	ı	BEIGHNOT		DATE	
	but I haven't be	•						
	Battilaventes	oon.						
	A Restorative	Nursing Program policy						
		provided by the						
	Administrator of	on 2/12/13 at 3:25 P.M.,						
		ollowing: "Purpose-To						
		ing program for						
		no longer need skilled						
	therapy, but still have functional goals							
		aintained through						
		epetition. The resident						
	•	aced on a program to						
		bility to function at his level within the given						
	-	These programs						
		se of skills that are						
		t utilized unless						
	· .	s or adaptations are						
	•	designed to foster						
	maximum inde	pendence in functional						
	activities Pro	cess-The program is						
		upervised and carried						
	, ,	staff preferably the						
		tor or MDS assistant						
	_	mentationC.N.A. will						
		he "Monthly Summary						
		per of minutes the						
		provided and their rative nursing programs						
		or Passive range of						
		king or Bed Mobility"						
	· · · · · · · · · · · · · · · · · · ·	ining of bod Mobility						
	3.1-35(g)(2)							

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Event ID: XZPZ11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM - 02/1	e survey pleted 2/2013		
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO309 SS=D FO309 SS=D FO309 SS=D A83.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240 (X5) PROVIDERS PLAN OF CORRECTION SEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE PREFIX TAG PROVIDERS PLAN OF CORRECTION SEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY What corrective action(s) will 03/05/201	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE (X4) ID PREFIX TAG FOOUBER PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOUBER PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOUBE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation FOOUBLE CENTRAL AVE GREENSBURG, IN 47240 (X5) PROVIDES PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (AS) COMPLETION COMPLETION DATE FOOUBLE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation FOOUBLE CARE/SERVICES DATE What corrective action(s) will O3/05/201			155625				02/12/	2013
ARBOR GROVE VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FO309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation SUMMARY STATEMENT OF DEFICIENCY ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE. PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETED. PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETED. PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE						ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
(X4) ID PREFIX TAG FO309 SS=D PROVIDER PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE FO309 SS=D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation FO309 What corrective action(s) will O3/05/201	NAME OF PE	ROVIDER OR SUPPLIER	· ·		1021 E	CENTRAL AVE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F0309 SS=D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation PREFIX TAG PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG What corrective action(s) will COMPLETION DATE COMPLETION DATE O3/05/201	ARBOR G	GROVE VILLAGE			GREEN	ISBURG, IN 47240		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F0309 SS=D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation F0309 What corrective action(s) will 03/05/201	` ′			PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION		
F0309 SS=D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation F0309 What corrective action(s) will 03/05/201		`				CROSS-REFERENCED TO THE APPROPRIA	.TE	
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation F0309 What corrective action(s) will 03/05/201			R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
and record review, the facility failed to administer, assess and treat pain in a timely manner for 2 of 3 residents reviewed for pain of 5 residents who met the criteria for pain. (Resident #A and #E) B.) Based on interview and record review, the facility failed to have a resident's advanced directive available for the facility nursing staff, resulting in CPR (Cardiac Pulmonary Resuscitation) being initiated for a resident who was a DNR (Do Not Resuscitate) code status for 1 of 1 resident reviewed who met the criteria for death. (Resident #90) Findings include: A.1.) The record of Resident #A was reviewed on 2/7/13 at 9:24 a.m. Resident #A's diagnoses included, but were not limited to, MRSA (Methicillin-Resistant-Stephylococcus Aureus), of the lungs, insomnia,		PROVIDE CARE HIGHEST WELL Each resident mumust provide the services to attain practicable physic psychosocial well the comprehensive care. A.) Based on it and record revadminister, asstimely manner reviewed for pamet the criteria #A and #E) B.) Based on it review, the fact resident's advailable for the resulting in CP Resuscitation) resident who was Resuscitate) or resident review for death. (Reference on 2/Resident #A's but were not ling (Methicillin-Resident)	BEING ust receive and the facility necessary care and or maintain the highest cal, mental, and Il-being, in accordance with ve assessment and plan of interview, observation iew, the facility failed to sess and treat pain in a for 2 of 3 residents ain of 5 residents who a for pain. (Resident interview and record illity failed to have a anced directive re facility nursing staff, rR (Cardiac Pulmonary being initiated for a was a DNR (Do Not ode status for 1 of 1 red who met the criteria resident #90) de: ord of Resident #A was r7/13 at 9:24 a.m. diagnoses included, mited to, MRSA sistant-Stephylococcus	F03	09	be accomplished for those residents found to have been affected by the deficient practice? Resident A no longer resides in the facility. Resident B pain has been assessed for pain and is recieving pain medication timely per orderResident # 90 no longer resides in the facility. How oth residents having the potentiat to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential be affected by the alleged deficient practices. All resident were assessed for pain by the DNS/designee. Any resident indicating pain, physician was notified for potential new physician orders, responsible also notified, and the resident's plan of care was updated. Licensed nurses were in-serviced on 2/28/13 by the Executive Director and the Director of Nursing Services or	ner al ee to ts see	03/05/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIC	00	COMPL	ETED
		155625	A. BUII B. WIN	LDING		02/12/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
ADDOD (GROVE VILLAGE				CENTRAL AVE ISBURG, IN 47240		
ARBUR	SROVE VILLAGE			GREEN	13BURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION SHOULD BE			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	pleural effusior	n (excess fluid between			complaints of pain and		
	the 2 pleural layers of the lungs) and depressive disorder. Resident #A's MDS (Minimum Data				administering pain medication	to	
					provide necessary care and		
					services timely.Any resident complaining of increased or		
					decreased pain will have a pai	n	
		ent, dated 1/15/13,			assessment completed,		
	· ·				interventions		
	indicated the fo	•			initiated, MD/responsible party	,	
	,	nterview for Mental			notified, pain medication		
	Status), 15, a s				administered per order and pl	an	
	indicating cogr	nition intact			of care updated, effectivness		
	- pain presence	e, yes			of any PRN pain medication w	ill	
	- on scheduled	l pain medication, no			also be documented in the		
	on PRN (as	needed), pain			progress notes. This will be monitored by the facility activit	v	
	medication, ye	, ·			report by the	у	
	· · · · · · · · · · · · · · · · · · ·	cy, almost constant			DNS/designee.Licensed nurse	es	
		le it hard for you to			were in-serviced on 2/28/13 by		
	•	· · · · · · · · · · · · · · · · · · ·			the Executive Director and		
	sleep at night,	•			Director of Nursing Services of	n	
	- pain intensity				code status for residents,		
	- should staff c	•			updating face sheet when stat	us	
	assessment, n	0			changed and reporting to	_	
					oncoming shift when status ha changed.100% audit was	S	
	Resident #A's	care plan, dated			completed on 2/26/2013 on		
	1/9/13, indicate	ed "Problem, Resident			resident's current code status	to	
	has pain relate	ed to, complaint of back			ensure available to nursing sta		
	· •	surgical pain. Goal,			by the Executive Director and		
		of pain within 30-60			SSD. Any resident found to no		
		rvention. Intervention,			have a current code status will		
		dication as ordered,			immediately be updated by		
					SSD/designee speaking to		
		n interventions such as			resident/responsible party for information, order obtained an	d	
	•	ronment, therapies as			resident face sheet and care p		
		otify physician if pain is			updated. Non-compliance wit		
	unrelieved and	l/or worsening."			these procedures will result in		
					further education including		
	Resident #A's	pain assessment,			disciplinary action.DNS/design	iee	
		ndicated "are you			are responsible to ensure		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155625	A. BUII B. WIN			02/12/2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹		l		
ADDOD (GROVE VILLAGE				CENTRAL AVE	
ARBUR	SROVE VILLAGE			GREEN	ISBURG, IN 47240	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	currently exper	riencing pain, yes.			complianceWhat measures w	ill
	Have you had	pain or hurting at any			be put into place or what	
		5 days, yes. Over the			systemic changes will be ma	de
		as pain made it hard			to ensure that the deficient	
	•	•			practice does not	
		o at night, yes. Over			recur? Licensed nurses were	
		s, have you limited your			in-serviced on 2/28/13 by the	
		ivities because of pain,			Executive Director and the	_
		the location of your			Director of Nursing Services of assessing residents with	.1
	pain, back. Ple	ease rate the intensity			complaints of pain and	
	of your worst p	ain over the last 5			administering pain medication	to
	davs. moderate	e. How much of the			provide necessary care and	
		experienced pain or			services timely. Any resident	
		e last 5 days, almost			complaining of increased or	
	_	pe of pain, aching."			decreased pain will have a pai	n
	Constantly. Ty	pe or pairi, acrillig.			assessment completed,	
					interventions	
		physician's order,			initiated, MD/responsible party	
	dated 1/9/13 a	t 10:09 a.m., faxed to			notified, pain medication	
	the pharmacy '	" Percocet (narcotic			administered per order and pl of care updated, effectivness	an
	analgesic) 5 m	g (milligrams)			of any PRN pain medication w	ill
	-acetaminophe	en (Tylenol), 325 mg,			also be documented in the	""
	•	tablets oral every 4			progress notes. This will be	
	hours PRN pai	•			monitored via the facility activity	ty
					report by the	
	Dogidont #Ala	nurging notes indicated			DNS/designee.Licensed nurse	
		nursing notes indicated			were in-serviced on 2/28/13 by	/
	the following:				the Executive Director and	
		5 p.m., resident has			Director of Nursing Services of	n
	surgical drain s	sites on back, there are			code status for residents,	ue l
	stitches, there	is no drainage or			updating face sheet when state changed and reporting to	uo
	redness				oncoming shift when status ha	s I
	- 1/9/13 at 6:15	5 p.m., resident			changed.100% audit was	
		or Grove Village			completed on 2/26/2013 on	
	accompanied b	_			resident's current code status	to
	· ·	•			ensure available to nursing sta	ıff
		wresident requested			by the Executive Director and	
	pain medicatio	n upon arrivai			SSD. Any resident found to no	
			L		have a current code status will	

A. BUILDING ————————————————————————————————————	MPLETED
155625	
133025 B. WING	12/2013
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
1021 E CENTRAL AVE	
ARBOR GROVE VILLAGE GREENSBURG, IN 47240	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (FACH DEFICIENCY MIST BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
The REGULTION OF ESCHELING WAREHOLD THE	DATE
1 000/1	
Administration (Accord), from the local	
nospital, dated 1/9/13 at 12:39 p.m., information, order obtained and	
indicated Resident #A received residetn face sheet and care plan	
Percocet 5 mg/acetaminophen 325 updated. Non-compliance with	
mg, 2 tablets, by mouth, with a pain these procedures will result in further education including	
rating at 6 on a pain scale of 0-10. Turther education including disciplinary action.DNS/designee are responsible to ensure	
Resident #A's MAR at the facility, compliance How the corrective	
dated 1/10/13 at 12:01 a.m., indicated action(s) will be maintained to	
Percocet 5 mg/325 mg ensure the deficient practice	
acetaminophen, 1 tablet given for will not recur, i.e., what quality	
complaint of pain assurance program will be put	
into place? The CQI tool	
During an interview on 2/11/13 at for pain management and advanced directives will be	
During an interview on 2/11/13 at advanced directives will be 2:58 p.m., the DON (Director of utilized weekly for 4 weeks and	
Nursing) indicated Resident #A had then monthly for 6 months.	
not received pain medication from Findings from the CQI process	
1/0/13 at 12:30 p.m. to 1/10/13 at	
Quality	
7.000.00.00 00.00.00 00.00	
EDR (Emergency Drug Rit) and the	
pharmacy had the required	
prescription to dispense the	
medication before Resident #A was	
admitted to the facility.	
A. 2.) During observation on 2-6-13 at	
9:37 a.m. Resident #E was groaning	
and had facial grimacing. Resident #E	
indicated she was hurt from a fall.	
Resident #E indicated it hurt to walk.	
During observation on 2-7-13 at 9:55	
a.m. Resident #E was being	
transferred from her bed to a	

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Event ID: XZPZ11 Facility ID: 000305

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155625	B. WIN	IG		02/12/	2013
NAME OF P	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOTTEIET	•			CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	wheelchair with	n the assistance of					
	CNA#3. The re	esident stated during					
	the transfer "ouch" and pointed to her						
	l •	d said it hurt. The					
		icial grimacing during					
		NA #3 indicated before					
	the resident ha	id a fall she walked					
	with a walker, a	and since she fell the					
	resident had be	een using the					
	wheelchair. Re	sident #E indicated it					
	was easier for	her to use the					
	wheelchair because hurt when she						
	walked with the	e walker.					
	Interview with I	Resident #E's family					
	member on 1-8	3-13 at 9:50 a.m.					
	indicated the re	esident did complain					
	about being in	pain. The family					
	member indica	ted they tell the					
	resident to ask	for pain medicine if					
	she is in pain.						
	Review of the I	record of Resident #E					
	on 2-7-13 at 11	1:45 a.m. indicated the					
	resident's diag	noses included, but					
	were not limite	d to, dementia,					
	hypertension, o	osteoporosis, shortness					
	of breath, aner	nia, cerebral vascular					
	accident (CVA)) (stroke), anxiety and					
	coronary artery	/ disease.					
	The Minimum I	Data Set (MDS)					
	assessment fo	r Resident #E, dated					
	11-3-12 indicat	ted the resident walked					
	in her room an	d corridor with limited					

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Event ID: XZPZ11

Facility ID: 000305

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		155625	B. WIN	NG		02/12/	2013
NAME OF E	PROVIDER OR SUPPLIE		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUPPLIE	N.		1021 E	CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	assistance of o	one person, the					
	resident had o	ccasionally had pain					
	and the pain h	ad made it hard for her					
	to sleep at nigl	ht. The resident's pain					
	was moderate	-					
	The safety eve	ent documentation for					
	Resident #E, c	dated 1-23-13 indicated					
	the resident ha	ad an unwitnessed fall.					
	The progress i	note for Resident #E,					
		at 11:39 a.m. indicated					
		arted dragging her right					
		ained of pain in her					
		resident had some					
		e back of her right leg. A					
	1	the physician to ask					
		her right hip and pelvis.					
		The right hip and pervis.					
	The progress i	note for Resident #E,					
		at 11:27 p.m. indicated					
		ontinued to complain of					
	pain in her leg						
		and bottom.					
	The progress i	note for Resident #E,					
		at 9:14 p.m. indicated					
		•					
	the resident st						
		being sore and not					
	feeling well.						
	The presence :	acts for Booldant #F					
		note for Resident #E,					
		indicated the resident's					
	x-rays were ne	egative for any					
	fractures.						

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Event ID: XZPZ11

Facility ID: 000305

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155625	B. WIN		<u> </u>	02/12/	2013
	PROVIDER OR SUPPLIER			1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE SBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1-30-13 indicat	or Resident #E, dated ted the resident had nplaints of moderate					
	#E, dated 1-30 resident had part the resident rapain. The resident	essment for Resident 1-13 indicated the 1-13 indicated the 1-13 indicated the 1-14 in the past 5 days. 1-15 indicated it as moderate 1-15 indicated her pain 1-16 in The resident had					
	Program Direct a.m. indicated medication give 1-25-13 or 1-26 experienced particles of the program Direct no non-pharma interventions dor 1-26-13 when experiencing particles of plan of care assessment for 1-30-13 because	the Memory Care tor on 2-11-13 at 9:30 there was no pain en to the resident on 6-13 when the resident ain. The Memory Care tor indicated there were accutical pain ocumented for 1-25-13 en the resident was ain. The Memory Care tor indicated there was e for pain or pain r Resident #E until se the resident did not upportive diagnosis for					
	on 2-11-13 at 2	agement policy e Director Of Nursing 2:00 p.m. indicated it policy to provide					

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Facility ID: 000305

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625		LDING	NSTRUCTION 00	(X3) DATE COMPL 02/12/	ETED
	PROVIDER OR SUPPLIE	3	1021 E	DDRESS, CITY, STATE, ZIP CODE CENTRAL AVE SBURG, IN 47240	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	or maintain the	e and services to attain e highest practicable al, and psychosocial luding pain				
	Resident #90 of a.m. indicated diagnoses inclimited to, cong	uded, but were not gestive heart failure, tension, chronic airway				
	most current d	s record indicated the ate the resident was e facility was on the resident passed 3.				
	for Resident # full code (Card Resuscitation any other life s needed) and the	record, dated 9-16-12 90 indicated he was a liopulmonary [CPR] will done and aving measures he name of the ex emergency contact				
	8-8-12 indicate chosen life sus goal was the re CPR and an a	or Resident #90, dated ed the resident had staining measures. The esident would receive mbulance would be erventions were assess				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	f 1	E SURVEY PLETED
		155625	A. BUILDING B. WING		02/1	2/2013
	PROVIDER OR SUPPLIER	.	STREET A 1021 E	ODDRESS, CITY, STATE, ZIP CO CENTRAL AVE SBURG, IN 47240	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
		y condition changes, comfortable and notify tion changes.				
	8-8-12 indicate on returning to goal was the redischarged to hinterventions we resident and fatransition to the resident and faprogress towar offer home evaluation. The social serva Resident #90, the resident's cosigned and data form was sent	ere explore with the				
	hospital Do No declaration and Resident #90's changed to DN had the residen witnessed by L documentation returned with the signature on 1-	d order" indicated code status was IR on 1-7-13. The form nt's name on it and was IR. The indicated the fax was ne physician's 1-7-13 at 3:53 p.m.				
	i ne progress r	note dated, 1-7-13 for				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155625	B. WIN	G		02/12/	2013
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1021 E	CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ndicated the resident					
		e unresponsive, no					
	pulse and no respirations. The nurse						
	called for assis	stance from another					
	nurse and beg	an CPR. The					
	Emergency Me	edic Team 911 was					
		IT's arrived at the					
		k over CPR for the					
	_	EMT asked what the					
		e status was and once					
		ed the resident was a					
		us they ceased CPR					
	and pronounce	-					
	-	1:38 p.m. The progress					
	note was signe						
	Tible was signe	cu by LPN #2.					
	Review of the I	Physician order for					
	Resident #90's	code status indicated					
	the resident's o	code status was					
		ONR. The order was					
	_	a full code to DNR on					
	1-7-13 at 11:58						
	1 7 10 41 11.00	, h					
	Interview with t	the Director Of Nursing					
	on 2-11-13 at 1	10:55 a.m. indicated					
	the fastest way	a nurse can tell what					
	,	de status was to look at					
		in the computer.					
		p					
	Interview with I	LPN #1 on 2-11-13 at					
		cated the order for					
		e status had been faxed					
		n on 1-7-13 on day					
		ndicated the second					
		uld have received the					
	Siliit nuise sno	ulu nave received the					

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Facility ID: 000305

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	OF CORRECTION IDENTIFICATION NUMBER: 155625	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/12/2013			
	PROVIDER OR SUPPLIER GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	fax. When queried about the date and time on the DNR fax order was 1-7-13 at 3:53 p.m. on day shift, LPN #1 indicated she did not know it had come back and the second shift nurse should have seen it in the resident's chart. LPN #1 indicated she did not know if the second shift nurse had been told in shift report that Resident #90's code status had been changed to a DNR. LPN #1 indicated it should have been reported in shift report to the second shift nurse. Interview with LPN #2 on 2-11-13 at 12:50 p.m. indicated he initiated CPR on Resident #90 on 1-7-13. LPN #2 indicated he had not been told in report that the resident's code status order had been received for the resident to be a DNR. LPN #2 indicated he was told in shift report that a fax had been sent to the physician, but it had not come back to the facility. LPN #2 indicated he started his shift on 1-7-13 at 6:00 p.m. LPN #2 indicated he looked at Resident #90's electronic health file and the resident chart and the resident was still a full code, so he initiated CPR on 1-7-13 because he could only go by what the resident's record said. LPN #2 indicated he had another nurse help him look for the resident's DNR order and they were						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED - 02/12/2013
	PROVIDER OR SUPPLIEF	.	1021 E	ADDRESS, CITY, STATE, ZIP CO CENTRAL AVE NSBURG, IN 47240	DDE
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
	indicated after over CPR, he was DNR order again hospice book in LPN #2 indicated told EMT's that DNR and they resident. LPN attried to figure of the told EMT's, but indicated after order for the D computer and code status from	e it either. LPN #2 EMT's arrived and took went searching for the ain and found it in the n the nursing station. ed he then went and it the resident was a ceased CPR on the #2 indicated he had out if the resident was a e he initiated CPR and it he resident's records as a full code. LPN #2 he found the physician NR he went into the changed the resident's im full code to DNR. g relates to complaint			

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Event ID: XZPZ11

Facility ID: 000305

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155625	B. WIN			02/12/	2013
	ROVIDER OR SUPPLIER			1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0312 SS=D	RESIDENTS A resident who is activities of daily necessary service nutrition, groomin hygiene. Based on obse record review,	unable to carry out living receives the es to maintain good g, and personal and oral ervation, interview, and the facility failed to	F03	12	What corrective action(s) wil be accomplished for those residents found to have beer		03/05/2013
	trimmed, nails, sampled for AE living), of 16 wl	ents with clean, for 2 of 4 residents DL's (activities of daily no met the criteria for ent #26 and #103).			affected by the deficient practice?Resident # 26 fingernails are clean and trimmedResident # 103 r longer resides at the facility. Hother residents having the potential to be affected by th same deficient practice will be	io Iow e e	
	reviewed on 2/ Her diagnoses limited to Parki osteoarthrosis, psychosis, con	myalgia, dementia, gestive heart failure, ctive pulmonary			identified and what corrective action(s) will be taken? All residents have the potential be affected by the alleged deficient practice. All resident nails were observed and cleaning/trimming was performed as needed by DNS and ADNS on 2/13/13. Nursing staff were in-serviced on 2/28/13 on providing ADL called	to 't's S	
	(Minimum Data dated 11/29/12 understood, an understand oth her Brief Intervindicating she wimpaired. She	d had the ability to ers. She scored 7 on iew for Mental Status,			for residents who are unable to carry out activities of daily living by the ED and DNS.Residents that are unable carry out activities of daily living will have their fingernails observed by nursing staff at le 2 times weekly during showers and prn to ensure nails are cleand trimmed, those residents are diabetic will have nails	e to ng ast s	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLII		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155625		LDING		02/12/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
ADDOD					CENTRAL AVE		
ARBUR	GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	transfer, and to	oileting. She required			trimmed by a licensed		
	extensive assis	st of 1 person to walk in			nurse. Non-compliance with the		
	her room, eat,	dress, and personal			procedures will result in furthe		
	hygiene.				education including disciplinar action.DNS/designee are	У	
					responsible to ensure		
	A Care Plan fo	r Resident #26			complianceWhat measures w	rill	
					be put into place or what		
	reviewed 11/29/12, indicated she				systemic changes will be ma	ıde	
		ce services. An			to ensure that the deficient		
	approach on her Care Plan indicated				practice does not		
	she would be cared for by the facility				recur? Nursing staff were		
	staff as well as	Hospice staff.			in-serviced on 2/28/13 on		
					providing ADL care for		
	On 2/7/13 at 11:21 A.M., Resident				residents who are unable		
		d in her wheelchair in			to carry out activities of daily	/	
		ning room with peers.			living by the ED and		
		nad no nail on her			DNS .Residents that are unabl		
					carry out activities of daily living	ng	
		finger of her left hand			will have their fingernails		
		her thumb of the right			observed by nursing staff at le 2 times weekly during shower		
	hand. Her nail	s were long, jagged,			prn to ensure nails are clean	anu	
	and discolored	yellow.			and trimmed, those residents	that	
					are diabetic will have nails		
	An interview w	ith CNA #7 on 2/7/13 at			trimmed by a licensed nurse.		
	11:36 A.M., inc	dicated if a resident			This will be monitored by the		
	· ·	, the nurses cared for			DNS/designee via shower she	eets	
	I	e indicated some of			and nail care		
					documentation. Non-compliar		
		nails were long and			with these procedures will res	ult	
	' ""	ey were discolored			in further education including		
	yellow.				disciplinary action.DNS/designare responsible to ensure	iee	
					compliance How the corrective	ve	
	An interview w	ith RN #8 on 2/7/13 at			action(s) will be maintained		
	12:13 P.M., ind	dicated Resident #26			ensure the deficient practice		
	· ·	and the nurses would			will not recur, i.e., what qual		
		for her nail care. RN			assurance program will be p		
	•	esident #26 was			into place? The CQI tool		
					for accommodation of needs v	vill	
	i mospice and tr	ne Hospice Aides gave					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLE	TED
		155625	B. WIN			02/12/2	013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R			CENTRAL AVE		
ARBOR (GROVE VILLAGE				ISBURG, IN 47240		
							77.5
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG		<u> </u>	+	IAU	be utilized weekly for 4 weeks	+	DATE
		shower 2 times a			and then monthly for 6 months		
		icated the Hospice	Findings from the CQI process				
		ident #26 at least			will be reviewed monthly by the		
	weekly. She ir	ndicated if the Hospice			Quality Assurance Committee		
	nurse did not p	rovide Resident #26			and an action plan will be		
	with her nail ca	re, it would be the			implemented for threshold belo	ow	
	facility's respor	nsibility. RN #8 said			90%.		
	she had just cli	ipped Resident #26's					
		were long and jagged.					
	,	3 7 33					
	On 2/7/13 at 13	2:15 P.M., Resident					
	#26 indicated the nurse had just						
		ls. Resident #26's					
		erved to be clipped to					
		• • •					
		length and clean at					
	that time.						
	· '	103's record was					
	revived on 1/12	2/13 at 1:45 P.M.					
	Resident #103	was admitted to the					
	facility on 1/16/	/13. His diagnoses					
	included but wa	as not limited to					
	Parkinsonism,	chronic obstructive					
		ease, osteoarthrosis,					
	'	hritis, joint pain, muscle					
		petes, and clostridium					
	difficile.	octes, and clostifican					
	difficite.						
	Posidont #103	's admission MDS					
		ated 1/23/13, indicated					
		elf understood, but					
	,	ood others. He required					
	extensive assis	stance of 2 persons for					
	transfers, bed i	mobility, and toileting.					
	He required tot	al dependence of 2					

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Event ID: XZPZ11

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	OF CORRECTION OF CORRECTION 155625	(X2) MULTIPLE CO A. BUILDING B. WING	00		
	PROVIDER OR SUPPLIER GROVE VILLAGE	1021 E	ADDRESS, CITY, STATE, ZIP COE CENTRAL AVE ISBURG, IN 47240	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	persons for dressing. He required extensive assistance of 1 person for personal hygiene. He did not walk. He was incontinent of bowel and bladder.				
	On 2/5/13 at 11:44 A.M., Resident #103 was observed lying in bed. He had long fingernails and there was dark substance underneath the nails, which was more prominent under his thumb and first finger nail of his left hand.				
	On 2/5/13 at 11:57 A.M., CNA #9 indicated she did not know why Resident #103's nails had not been trimmed. She indicated his nails may be dirty because he dug at his private areas. She indicated his nails were long and had been since he was admitted.				
	3.1-38(a)(3)(E)				

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Event ID: XZPZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155625	A. BUII B. WIN			02/12/	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
40000					CENTRAL AVE		
ARBUR (GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
F0323	483.25(h)						
SS=D	FREE OF ACCID	ENT					
	HAZARDS/SUPE	RVISION/DEVICES					
	The facility must e	ensure that the resident					
	environment rema	ains as free of accident					
	hazards as is pos	sible; and each resident					
		e supervision and					
	assistance device	es to prevent accidents.					
	Based on obse	rvation, interview, and	F03	23	What corrective action(s) will		03/05/2013
		the facility failed to			be accomplished for those		
	•	interventions for 1 of 4			residents found to have been	ı	
	•	wed for accidents, for 6			affected by the deficient		
					practice?Resident #39 no		
		iteria for accidents.			longer resides at the		
	(Resident #39)				facility.How other residents		
					having the potential to be		
	Findings includ	e:			affected by the same deficier	ıt	
	J				practice will be identified and		
	Resident #30's	record was reviewed			what corrective action(s) will		
	on 2/8/13 at 10				be taken?All residents have t	he	
					potential to be affected by the	е	
	~	uded but was not			alleged deficient		
	• •	nosis, senile dementia			practiceNursing staff		
	with depression	n, osteoarthrosis, and			were re-educated on 2/28/13		
	subdural hema	toma.			on fall		
					policy/procedure/interventions	,	
	Fall Event Ren	orts for Resident #39			the ED and DNS.An audit was		
	•	ollowing: Event date:			completed on all fall risk reside		
		•			to ensure interventions were in		
		5 P.MResident #39			place and functioning, and that	L	
		essed fall. She was			their care plan and c.n.a. assignment sheet were		
	first observed ly	ying face down in the			updated. This will be complete	d	
	main dining roo	om. She had a			by the IDT by	~	
	hematoma to h				3/4/2013. Non-compliance with	1	
		ut into place to prevent			these procedures will result in		
	another fall incl				further education including		
					disciplinary action.DNS/design	ee	
	•	Therapy) and PT			are responsible to ensure		
	` •	apy) would evaluate			complianceWhat measures w	ill	
	Resident #39 a	and she would			be put into place or what		
			I				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625			ULTIPLE CO LDING	00	(X3) DATE SU COMPLE 02/12/2	TED	
		155625	B. WIN	G		02/12/2	013
	PROVIDER OR SUPPLIER GROVE VILLAGE			1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE ISBURG, IN 47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	12/14/12 at 9:2 had an unwither been trying to the unable to, so so the was observed on the been trying to so was observed on her buttock. Underwear and Interventions phanother fall incomplete been trying to so was observed on her buttock. Underwear and Interventions phanother fall incomplete been trying to so was observed on her buttock. Underwear and Interventions phanother fall incomplete been trying to so was observed on her buttock. Underwear and Interventions phanother fall incomplete been trying on her back could not slide personal alarm at 5:55 P.MResing on her back intervention been trying on her back intervention her back. Intervention her back intervention her intervention in front could be sitting in front of clothed, with her placed in her residual in the place	assist. Event date: O P.MResident #39 essed fall. She had eurn her TV off and was he went to get help. Ved lying in the hallway droom on her right ed, with no shoes on. ut into place to prevent luded a pressure alarm her bed. Event date: 31 A.MResident #39 essed fall. She had sit in her recliner. She esitting in her bedroom She had on I shoes, but no pants. ut into place to prevent luded her chair would against the wall so it She would have a Event date: 12/16/12 esident #39 had an III. She was observed throom floor. She he to the top of her tions put into place to er fall included a floor ent date: 12/21/12 at dent #39 had an III. She was observed of her recliner, fully er shoes on. She was ecliner with a pressure she was found on the			systemic changes will be mato ensure that the deficient practice does not recur? Nursing staff were re-educated on 2/28/13 on fall policy/procedure/interventions the ED and DNS. An audit was completed on all fall risk resid to ensure interventions were in place and functioning, and that their care plan and c.n.a. assignment sheet were update. This will be completed by the by 3/4/2013. Rounds will be completed daily by the DNS/designee to ensure that interventions are in place according to the resident's placare. Non-compliance with the procedures will result in furthe education including disciplinar action. DNS/designee are responsible to ensure compliance How the correctivaction(s) will be maintained ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place? The CQI audit tool for fall management will be utilized weekly for 4 weeks then mont for 6 months. Findings from the CQI procuit will be reviewed monthly by the Quality Assurance Committee and an action plan will be implemented for threshold belinglemented for threshold b	by sents on the second of the	

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Event ID: XZPZ11

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLI	ETED
		155625	B. WIN			02/12/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	CROSS-R		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		box was on the					
		the pad was still in her					
	recliner. Interventions put into place to prevent another fall included the						
	Dr. was there a	and would evaluate her.					
	The alarm box	would be placed out of					
	her reach. Resident #39's significant change MDS (Minimum Data Set)						
	assessment da	ated 12/27/12, indicated					
	she understood and was able to understand others, she scored 4 on						
		riew for Mental Status,					
		cognitive status was					
	_	red. She required					
		<u>-</u>					
		stance of 2 persons for					
		ransfers, to walk in her					
	room, dressing						
		ne. She was only able					
		n human assistance to:					
		a seated to standing					
	-	alk (with and assistive					
	,	. 3. Turning around					
	and facing the	opposite direction					
	while walking.	4. Moving on and off					
	the toilet. 5. S	urface to surface					
	transfers (trans	sfer between the bed					
	and chair or wl	heelchair). She utilized					
		wheelchair. She had					
	2 or more falls.						
	A Care Plan fo	r Resident #39 dated					
		ted the following:					
		nad an acute change in					
	1.03100111 #38	iad an addie drange in					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155625	B. WIN		-	02/12/	2013
NAME OF B					ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF P	PROVIDER OR SUPPLIEF	ę.		1021 E	CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ental status due to a					
	chronic subdur						
	Resident #39's goal was to return to						
	her previous m	nental status.					
	 Fall Event Ren	orts for Resident #39					
	•	ollowing: Event date:					
		B P.MResident #39					
		ed fall. She was being					
		restroom and was					
		floor. She was fully					
	clothed with he	3					
		out into place to prevent					
	•	luded assist times 2.					
		illueu assist times 2.					
	A Care Plan fo	r Resident #39 dated					
		odated 1/29/13,					
	·	ollowing: Resident #39					
		falls due to being over					
	80 years old, a	_					
		ives, anti-convulsants,					
		nired gait/balance,					
	•	ontinence, a history of					
	falls in the past	·					
	•	es. Resident #39's					
		free from fall related					
	_	proach for Resident					
	'	•					
		29/13, indicated there					
		arming mat in front of					
	her recliner.						
	A physician's c	orders for Resident #39					
	indicated the fo						
		mat in front of recliner.					
		tions: Indications					
		นอกร. เกิดเอสเบาร					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155625	B. WIN			02/12/	2013
	ROVIDER OR SUPPLIER	2	<u>'</u>	1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE ISBURG, IN 47240		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	**************************************		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	decreased safe risk."	ety awareness. Fall					
	On 2/7/13 at 10	0:57 A.M., Resident					
		ved seated in her					
		bedroom. She had					
		urple discoloration in					
	.	er forehead and under					
		Resident #39 indicated					
		and did not need help					
		ped. She had a skid					
		legs of her recliner and					
		at under her feet in					
	front of her rec						
	On 2/8/13 at 9 ⁻	:24 A.M., Resident #39					
		seated in her recliner in					
		She indicated she was					
		supper and she hadn't					
	_	She displayed some					
	_	e pointed at her					
		d indicated she was					
		it because she felt she					
	_	had a skid mat under					
	U	recliner and another					
	_	her feet in front of the					
	recliner.						
	TCGIITICI.						
	On 2/8/13 at 1	2:17 P.M., RN #6					
		dent #39 had an					
		ying on the floor by her					
		front of her recliner.					
		the approach on the					
		Care Plan indicating					
	an alarming ma	at would be placed in					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/12/2013
	PROVIDER OR SUPPLIE GROVE VILLAGE	R	1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE NSBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	front of the red clarified.	liner needed to be			
	indicated she form the Directory and the alarming have been in forecliner.	:56 P.M., RN #6 received clarification tor of Nursing (DoN) ng floor mat should ront of Resident #39's			
	indicated the f 9:41 P.M. Res unwitnessed fa sitting up, dres in her room. she was trying Interventions p	out into place to prevent cluded she would be			
	#39 was observed recliner in her skid mat unde and another slin front of the relindicated the abeside Reside utilized when sindicated the anot used in from recliner.	9:48 A.M., Resident rved seated in her bedroom. She had a r the legs of her recliner kid mat under her feet recliner. CNA #7 alarming floor mat lying nt #39's bed was she was in bed. She alarming floor mat was nt of Resident #39's			
	An interview w	vith LPN #1 on 2/11/13			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	LDING	NSTRUCTION 00	(X3) DATE : COMPL 02/12/	ETED
	PROVIDER OR SUPPLIER		1021 E	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE SBURG, IN 47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	used the alarm her bed and unher recliner. LI alarming floor red bed to under R Resident #39's staff, and provi 2/11/13 at 10:1 Resident #39 v floor mat in from On 2/12/13 at 9 #39 was observed in her between the state of the	used. She stated "I'm going to Kentucky and				

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STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE			JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155625	B. WIN			02/12/	2013
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIER				CENTRAL AVE		
ARBOR (GROVE VILLAGE			GREEN	ISBURG, IN 47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0325 SS=D	483.25(i) MAINTAIN NUTR UNAVOIDABLE Based on a reside assessment, the fresident - (1) Maintains acconstrictional status, protein levels, unlessed on interventional problems and (2) Receives a the anutritional problems and (2) Receives a the anutritional problems and interventional problems and interventional problems and interventional problems for 1 of 3 register weight loss and any interventional loss for 1 of 3 register weight loss of 8 the criteria for reference with the criteria for reference with the criteria for register in t	view and record dity failed to notify the resident's significant d failed to implement ns to prevent weight residents reviewed for 3 residents who met nutrition (Resident e: record of Resident #52 0:00 a.m. indicated the noses included, but d to, congestive heart anxiety, paraplegia and sis (MS). vas admitted to the 12 and weighed 126	F03	25	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 52 no longer resides at the facility. How other residents having the potentiat to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practiceLicensed nurses were educated on notifying a Physician for any resident with a significant weight loss, and to implement interventions to prevent weight loss by the ED and DNS on 2/28/2013. All residents were reviewed for significant weight loss by the DNS/designee. No other residents were	l al e to	DATE 03/05/2013
	8-30-12 was 11	esident's weight on 15; this indicated a 8.7 n six days. The			identified.Residents identified of a significant weight loss or gain will be reviewed in weekly NAF	n	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DD	NG	00	COMPL	ETED
		155625	A. BUILDIN B. WING	NG		02/12/	2013
				TDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			CENTRAL AVE		
ADB∩D.	GROVE VILLAGE				SBURG, IN 47240		
ANDON	GROVE VILLAGE			JINEEIN	3BUNG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
	resident's wei	ght on 9-23-12 was 116			meeting to include weight hist	ory,	
	pounds; this in	ndicated a 7.9% weight			current nutrition regimen, oral		
	loss in less th	an one month. The			status, observations during meals, root cause, plan of car	•	
	resident was	discharged from the			updated, and physician and	C	
	facility on 9-2	•			responsible party were notified	d -	
		·			to be attended by the DM, RD		
	The physician	order for Desident #52			available, DNS, RSM, MDS		
		order for Resident #52,			Coordinator, and/or		
		2 indicated the resident			Designees.Non-compliance w		
		a low sodium regular			these procedures will result in		
	diet.				further education including		
					disciplinary action.DNS/design	nee	
	The Minimum	Data Set (MDS)			are responsible to ensure	.:11	
	assessment for	or Resident #52, dated			complianceWhat measures we be put into place or what	/111	
	8-31-12 indica	ated the resident was			systemic changes will be ma	ndo	
		ician prescribed weight			to ensure that the deficient	iue	
	loss regimen.	iolan procensed troigin			practice does not		
	l 1033 regimen.				recur? Licensed nurses		
	The plan of or	ore for Decident #F2			were educated on notifying a		
	-	are for Resident #52,			Physician for any resident with	n a	
		2 indicated the resident			significant weight loss, and to		
	-	erapeutic diet due to			implement interventions to		
	CHF. The inte	erventions were as			prevent weight loss by the ED		
	follows: honor	the resident's known			and DNS on		
	food preferen	ces that were within			2/28/2013. Residents identifie		
	limitations of I	ner diet restriction, to			with a significant weight loss of		
		esident's food/fluid			gain will be reviewed in weekl NAR meeting to include weigh		
		ls, monitor the resident's			history, current nutrition regim		
		the Medical Doctor of			oral status, observations durin		
	, ,				meals, root cause, plan of car		
		t weight changes, offer			updated, and physician and		
		ubstitutes if less than			responsible party notified - to	be	
	1	eal is consumed,			attended by the DM, RD if		
	provide the di	et per Medical Doctor			available, DNS, RSM, MDS		
	orders and re	view the resident's labs			Coordinator, and/or	ith.	
	as available.				designees. Non-compliance w these procedures will result in		
					further education including		
	The record of	Resident #52 indicated			disciplinary action.DNS/design	nee	
	1	. tooladiit // oz illaloatoa			and a partial y action is break doorgi		l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155625	B. WIN			02/12/	2013
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	F	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
ARBOR (GROVE VILLAGE				ISBURG, IN 47240		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		tion addressing the			are responsible to ensure complianceHow the corrective	Δ.	
	resident's signi	ificant weight loss.			action(s) will be maintained t		
					ensure the deficient practice		
		the Director of Nursing			will not recur, i.e., what quali		
	, ,	!-13 at 9:25 a.m.			assurance program will be p	ut	
		hysician was not			into place?		
		ident #52's weight loss.			·The CQI audit tool for resid- weights will be utilized weekly		
		ated Resident #52's			4 weeks then monthly for	101	
		swollen and it was felt			6 months.		
		er abdomen was what			·Findings from the CQI proc		
		e resident's significant			will be reviewed monthly by th Quality Assurance Committee		
		ne DON indicated there			and an action plan will be		
		entation or assessment			implemented for threshold bel	ow	
		ne resident's abdomen.			90%.		
		eated there were no					
		nplemented for the					
	resident's weig	INT IOSS.					
	Interview with t	the Dietary Manager on					
	2-12-13 at 10:1	15 a.m. indicated					
	nursing was re	sponsible to notify the					
	physician of Re	esident #52's significant					
	weight loss. Th	ne Dietary Manager					
	indicated Resid	dent #52 was placed on					
	a nutritional at	risk committee when					
	she was admit	ted to the facility					
	because all ne	w residents were					
	placed on the	committee. The Dietary					
	Manger indicat	ed there were no					
	interventions p	ut in place for the					
	resident's signi	ificant weight loss.					
	The weight pol	icy provided by the					
		on 2-12-13 at 11:15					
	a.m. indicated	the nursing department					

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	of Correction identification number: 155625	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 02/12	LETED			
	PROVIDER OR SUPPLIER GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE			
	is responsible for identifying the resident with a significant unplanned weight loss/gain and meeting with the Dietary service Manager. The physician was also notified of significant or undesirable weight change. 3.1-46(a)(1)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155625	B. WIN	G		02/12/	2013
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0425 SS=D	483.60(a),(b) PHARMACEUTIC PROCEDURES, The facility must personnel to admorphisms, but only supervision of a li A facility must proservices (including the accurate acquaispensing, and a and biologicals) to resident. The facility must especially must be accurate acquaispensing, and a and biologicals) to resident. The facility must especially must be services of a licer provides consultated provision of pharmased on interview, the facing sleeping medication to residents remedications. Findings included the record of Freviewed on 2/2 Resident #A's consultations.	CAL SVC - ACCURATE RPH provide routine and and biologicals to its in them under an bed in §483.75(h) of this may permit unlicensed inister drugs if State law under the general censed nurse. Evide pharmaceutical g procedures that assure uiring, receiving, administering of all drugs to meet the needs of each employ or obtain the the needs of the macy services in the facility. Eview and record lity failed to obtain a station for 7 days after was ordered, for 1 of viewed for (Resident #A)	F04		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident A no long resides at the facilityHow oth residents having the potentiat to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practiceLicensed nurses were educated on providing routine medication to residents per physician order, obtaining a script	er eer al	03/05/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLE	TED
		155625	B. WIN			02/12/2	2013
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			CENTRAL AVE		
ADROD (GROVE VILLAGE				ISBURG, IN 47240		
ANDON	SKOVE VILLAGE			GKEEN	NSBORG, IN 47240		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the 2 pleural la	yers) and depressive			timely for a controlled		
	disorder.				substance, notifing		
					physician/alternative		
	Resident #A's	MDS (Minimum Data			physician when medication	is	
		ent, dated 1/15/13,			not available as well as		
	· '				responsible party per the		
		6 (Brief Interview for			DNS/designee on 2/28/13.A		
	,	. 15, a score of 13-15			controlled substances will l		
	indicating cogr	nition intact.			reviewed to ensure that the		
					meds ordered are available	το	
	Resident #A's	care plan, date			residents timely, any	ماماد	
	1/26/13, "Problem, Resident has diagnoses of insomnia and may				medication found not availa	ible	
					will have the attending		
	•	us or upset due to			Physician/alternate/pharma notified immediately by the	-	
		•			charge nurse as well as the		
		ep or lack of sleep.			responsible party. This will		
		t will have less difficulty			completed by the DNS and		
	sleeping. Inte	erventions, may become			ADNS by 3/1/2013.All new		
	anxious or ups	set due to inability to			orders for a controlled		
	sleep or lack o	f sleep, 1 staff to offer			substance will be reviewed		
	to walk through	h facility with resident to			daily to ensure availability v	was	
		eel tired and 2 staff to			timely by the		
	1 '	as this may help			IDT/designee.Non-compliand	ce	
	resident relax.	as this may neip			with these procedures will re	sult	
	resident relax.				in further education including		
					disciplinary action.DNS/design	gnee	
		physician's orders,			are responsible to ensure		
	·	indicated "Ambien			complianceWhat measures	will	
	(insomnia med	lication) 10 mg			be put into place or what		
	(milligrams), by	y mouth, once a day at			systemic changes will be m		
	8:00 p.m."	-			to ensure that the deficient		
					practice does not recur? Licensed nurses we	_	
	Resident #4's	nursing notes dated			educated on providing rout	-	
		•			medications to residents pe		
		9 p.m., indicated			physician order, obtaining a		
		dent, nurse will contact			script timely for a controlle		
		n concerning pain			substance, notifing	· ·	
	issues. Reside	ent also concerned with			physician/alternative		
	Ambien. Infori	med resident the			pyololaliiallollialivo		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155625	B. WIN			02/12/2013
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIE	R			CENTRAL AVE	
ΔRR∩R (GROVE VILLAGE				ISBURG, IN 47240	
					, , , , , , , , , , , , , , , , , , ,	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		order the medication but			physician when medication i	S
	has not sent in	script to the pharmacy			not available as well as	
	yet. Stated once that script is there,				responsible party per the	
	the pharmacy	will deliver the meds to			DNS/designee on 2/28/13.All	
		ormed resident, nurses			controlled substances will be reviewed to ensure that the	e
	1	ing her physician			meds ordered are available t	•
		ript but unsure at this			residents timely, any	°
		-			medication found not availab	nle
		in has contacted the			will have the attending	
	1	it the issue. Nurse			Physician/alternate/pharmac	v
states going to call resident's physician again today."				notified immediately by the	´	
				charge nurse as well as the		
	Resident #A's MAR (Medication				responsible party. This will b	oe e
					completed by the DNS and	
	Administration	Record), indicated			ADNS by 3/1/2013.All new	
		g, once a day was not			orders for a controlled	
		en on 1/20/13 and			substance will be reviewed	
	_	/19/13, 1/21/13,			daily to ensure availability w	as
		13 and 1/24/13, reason			timely by the	
		·			IDT/designee.Non-compliance	
		ed was documented as			with these procedures will resin further education including	uit
	drug/item una	vallable."			disciplinary action.DNS/design	nee
					are responsible to ensure	
	_	view on 2/11/13 at			compliance How the corrective	ve
		DON (Director of			action(s) will be maintained t	
	Nursing) indica	ated "when we have a			ensure the deficient practice	(
	controlled subs	stance order from the			will not recur, i.e., what quali	ity
	physician like	Ambien it is only valid			assurance program will be p	ut
	1 ' '	macy is faxed. No			into place?	
	order will be se	-			·The CQI audit tool for	
		authorization is			pharmacy services will be utili	
					weekly for 4 weeks then mont for 6 months.	niy
		the physician. We			Findings from the CQI proc	P88
	, , ,	et a copy of the script			will be reviewed monthly by th	
	but if we started the Ambien on				Quality Assurance Committee	
	1/26/13 then th	nat is when the			and an action plan will be	
	pharmacy rece	eived the prescription."			implemented for threshold bel	ow
		-			90%.	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155625		A. BUILDING B. WING	COMPLETED 02/12/2013					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	This federal tag IN00123230.	g relates to complaint						
	3.1-25(a)							

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